Centers for Medicare and Medicaid Services

STATE OF VERMONT
"CHOICES FOR CARE"
DEMONSTRATION WAIVER

OPERATIONAL PROTOCOL

July 1, 2005

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Section A: Organization & Structural Administration

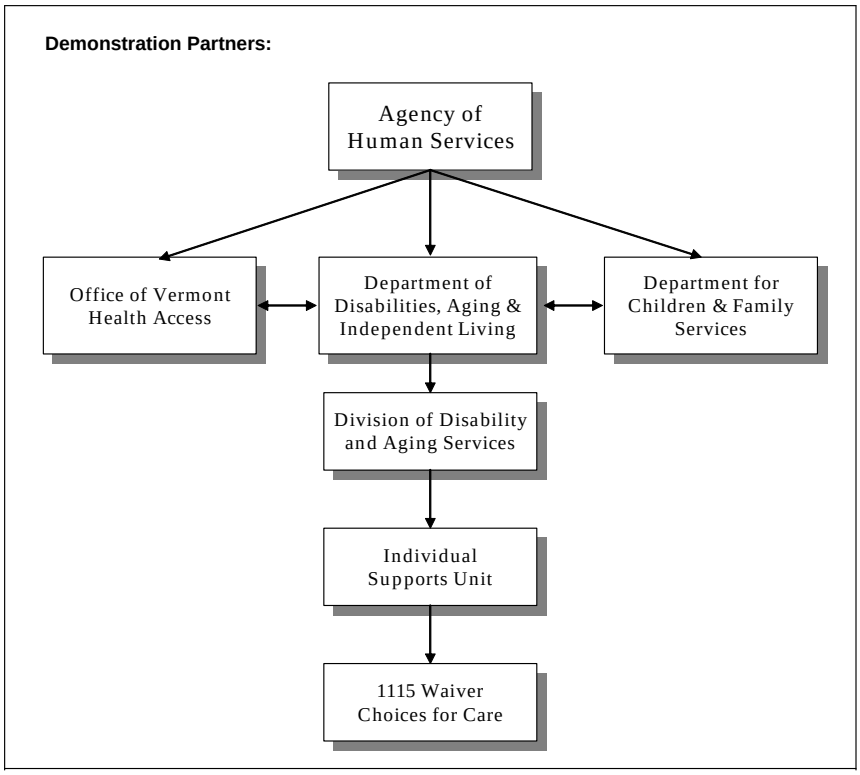
The State of Vermont has a well-regarded history of managing the state's publicly funded health care system to maximize the number of persons with health coverage while containing costs. In an effort to further improve its programs, the state developed this demonstration initiative to provide greater choice and the highest quality services possible to recipients in need of long-term care.

Through this demonstration the Vermont Agency of Human Services (AHS) will undertake broad based reform of the long-term care service system by offering a continuum of care that includes a series of options, including both home- and community-based alternatives and traditional nursing facility services. All persons eligible for Medicaid who meet the clinical criteria for long-term care services in two of three clinical categories (Highest Need and High Need) will be enrolled in the demonstration program. Services will be provided on an entitlement basis to those in the Highest Need group. Those in the High Need group will be served to the extent that funds are available.[1] Additionally, the state will expand eligibility to include individuals who meet the state's financial eligibility criteria and the clinical criteria for a new level of care – those with Moderate Needs. The Moderate Need group will have access to a limited array of home- and community-based services, subject to available program funding. A full description of the eligibility criteria and benefit package for each of the three clinical groups is included in later sections of this Operational Protocol.

The Department of Disabilities, Aging and Independent Living (DAIL) is the lead entity for this effort within AHS. Partners include the Office of Vermont Health Access (OVHA), the Department for Children and Families (DCF), and the range of local organizations and entities currently delivering long-term care services to Vermonters. These partners have been involved in the design and development of this project and will continue to take an active role as it is implemented.

Following is an organizational chart depicting the relationships among the various partners in the demonstration.

[1] *Current participants in the state's HCBS waivers are "grandfathered" into this demonstration. These individuals will continue to be served even if they are categorized as High Need versus Highest Need.*



The Department has identified eight functional areas necessary to support its core business operations for the demonstration. These units will have the primary responsibility for distinct operational processes necessary to administer the demonstration. The eight functional units within DAIL that are charged with the responsibility for administering this demonstration are:

- Clinical Services and Program Development
- Provider Network Development and Relations
- Quality Management and Improvement
- Research and Evaluation
- Enrollee and Family Services
- Utilization Management
- Financial Management
- Information Systems

Table 1 summarizes the tasks that are being completed to support the start-up and ongoing operations of the demonstration. The chart includes information on the expected dates of completion, status as an ongoing activity, and the organizational unit responsible for the task area.

Table 1: Tasks and Timeline

TASK	COMPLETION DATE	ORGANIZATION/ UNIT
Development of Policies and Procedures	July 2005	• Clinical Services & Program Development Unit / Department of Disabilities, Aging and Independent Living • Department for Children and Families / Economic Services Division • Office of Vermont Health Access
Recruitment of Staff	July 2005	• Division of Disability and Aging Services / Dept of Disabilities, Aging and Independent Living
Training of Staff	July - September 2005 Monthly oversight and assistance during Year 1 Quarterly updates ongoing	• Division of Disability and Aging Service • Department of Children and Family Services / Economic Services Division • Division of Licensing and Protection
Training Community Partners	July - September 2005 Quarterly review during Year 1 Semi-annual training Ongoing	• Division of Disability and Aging Service • Department for Children and Families / Economic Services Division • Division of Licensing and Protection
Marketing & Outreach	May 2005 and ongoing	• Division of Disability and Aging Services • Community Partners • Media
Member Education & Enrollment	September 2005 and ongoing	• Division of Disability and Aging Services / Program Unit
Provider Development & Relations	August 2005	• Division of Disability and Aging Services / Program Unit • Community Services Unit

TASK	COMPLETION DATE	ORGANIZATION/ UNIT
Utilization Review	Ongoing	• Division of Disability and Aging Services / Utilization Review Unit • Department of Disabilities, Aging and Independent Living / Long-Term Care Clinical Coordinators • Division of Licensing and Protection staff (as needed)
Quality Monitoring & Management	Ongoing	• Department of Disabilities, Aging and Independent Living / Long-Term Care Clinical Coordinators • Department of Disabilities, Aging and Independent Living -Utilization Review Staff • Division of Licensing and Protection staff • Department of Disabilities, Aging and Independent Living / QA / QI staff
Financial Management	Monthly	• Department of Disabilities, Aging and Independent Living / Business Office Staff
Research & Evaluation	Year 2 and ongoing	Contractor – TBD
Information Systems	Monthly	• Department of Disabilities, Aging and Independent Living / Information Systems Unit

Section B: Reporting Items

As required under the Special Terms and Conditions governing this demonstration, DAIL will provide comprehensive reporting to CMS on all aspects of the program. The plan for reporting on the demonstration is summarized below.

Monthly Progress Calls

During the first six months of operations, DAIL will hold monthly conference calls with CMS to discuss the demonstration's progress. This will include a discussion of any implementation and start-up issues that may arise. Thereafter, update calls will be held at a frequency determined by DAIL and CMS.

Quarterly & Annual Progress Reports

DAIL will submit quarterly progress reports to CMS within 60 days of the close of each quarter. The fourth quarter report each year shall include an overview of activities for the entire year and will serve as the annual progress report. The reports will include, at a minimum, the following information.

- a discussion of the events occurring during the quarter (including enrollment numbers, lessons learned, and a summary of expenditures.
- a discussion of the state's progress in completing certain quality assurance and quality improvement plan activities
- a list of notable accomplishments
- a summary of any problems/issues encountered and how they were resolved

Final Demonstration & Evaluation Report

At the end of the demonstration period, a final draft report will be submitted to CMS for comments. DAIL will take CMS' comments into consideration and incorporate them into the final report. The final report will be submitted to CMS no later than 180 days after the termination of the project.

Financial Reporting

Form CMS-64 will be submitted quarterly within 30 days of the end of the quarter. This report will include total expenditures for services provided under the Medicaid program, including those provided through this demonstration.

Applicable rebates and expenditures subject to the budget neutrality cap will be reported on five separate Forms CMS-64.9 WAIVER and 64.9P WAIVER for each demonstration year, for each of the MEGs as follows:

- Form 1: Expenditures for the Highest Need group
- Form 2: Expenditures for the High Need group
- Form 3: Expenditures for the Moderate Need group
- Form 4: Expenditures for the demonstration eligibles who also receive CRT services
- Form 5: Expenditures for PACE Vermont participants

Cost settlements will be reported on line 10.b. Cost settlements not attributable to this demonstration will be reported on lines 9 or 10.c.

All administrative costs for the demonstration will be reported on Forms CMS-64.10 WAIVER and / or 64.10P WAIVER.

Form CMS-37 will be filed quarterly with an estimate of the quarterly expenditures under the demonstration for both the Medical Assistance Program and Administrative Costs. The state will also file a supplement to Form CMS-37 which provided updated estimates of expenditures subject the budget neutrality cap.

Section C: Implementation of MMA Drug Benefit

The Department is working closely with a variety of state and community partners to ensure that a comprehensive information and outreach campaign successfully reaches Vermonters eligible for the Medicare Modernization Act (MMA) Part D drug benefit. The partners involved include OVHA, the Department of Children and Families/Economic Services Division, the Social Security Administration and the Vermont Area Agencies on Aging.

Training on the MMA benefit and eligibility criteria began in April 2005 through the State Health Insurance Assistance Program (SHIP) operated by the five Area Agencies on Aging. Several sessions will be offered to a wide audience beginning with "MMA 101" and will be continued through the initial implementation periods of the new drug benefit program. Sessions will be also be targeted to a wide range of local providers.

DAIL management and staff will also instruct case management supervisors in the elements of the program so that they can offer ongoing training to their line staff. The DAIL Long-Term Care Clinical Coordinators (LTCCCs) will take part in all types of training sessions offered. Informational meetings and training sessions will continue throughout the year.

Accordingly, both the LTCCCs and the local case managers will be well versed in the particulars of the MMA Part D prescription drug benefit program. As these staff interview potential applicants for the demonstration program, they will inquire as to the individual's status and eligibility for the Medicare Part D benefits. The referral form used for the program includes an indicator with respect to Medicare eligibility. Therefore, the staff will be aware of the person's eligibility for Part D. Individuals who are dually eligible for Medicaid will have "wraparound" pharmacy coverage through that program (see below).

The State of Vermont is also implementing changes to its pharmacy programs for dually eligible (Medicare and Medicaid) beneficiaries effective January 1, 2006 to incorporate the requirements of the Medicare Modernization Act. This includes the development of a program to pay the recipient's cost sharing obligations under Part D and to provide coverage for drugs in excluded categories under the Part D benefit (e.g., Benzodiazepines and Barbiturates). All beneficiaries served through this long-term care demonstration who have full Medicaid coverage in addition to Medicare will have "wraparound" pharmacy benefits provided through the Vermont Medicaid program. Local case managers and the LTCCCs will provide participant education on the Part D program and the Medicaid wraparound drug benefits.

The Agency of Human Services, the Single State Agency for Medicaid in Vermont, is now updating its reporting requirements to accommodate the changes brought about by the Medicare Modernization Act. These requirements will continue to be modified as necessary in CY2006 and beyond to reflect the Vermont Medicaid program's role as the secondary and supplemental payor to Medicare's Part D program for the dually eligible population. These financial and reporting changes will be incorporated into the reporting requirements for the 1115 LTC demonstration waiver.

Section D: Reporting on LTC Demonstration Participants who are Receiving Community Rehabilitation & Treatment Services

Individuals who meet the clinical criteria for the long-term care demonstration and are enrolled in that program may also receive Community Rehabilitation and Treatment (CRT) services if they have severe and persistent mental illness and qualify for services under the state's CRT waiver program. These individuals will be dually enrolled in both the long-term care demonstration and the VHAP/CRT program.[2]

Vermont will implement a tracking and reporting system that separately identifies any expenditures for CRT services provided to participants enrolled in the long-term care demonstration. The CRT expenditures for those dually served through the long-term care and VHAP/CRT demonstration waiver programs will be reported under the VHAP waiver and will be accounted for under the budget neutrality limits of that waiver. Expenditures for all other services provided to such individuals will be reported under the LTC demonstration and accounted for through that waiver's distinct budget neutrality limit.

A separate CMS-64.9 form will be filed quarterly for the CRT Medicaid Eligibility Group (MEG). This will include individuals who are enrolled in the long-term care demonstration, but who are also receiving CRT services.

[2] *The CRT waiver program is operated under the auspices of the VHAP Section 1115 demonstration waiver.*

Section E: Reporting on Participants who would be Included in PACE Vermont

Overview

From the beginning, PACE programs have collected data about their enrollees in order to more effectively serve PACE participants and demonstrate the effectiveness of the model of care. Utilization and Census information for PACE Vermont will be collected through DataPACE. DataPACE is a comprehensive data collection program that provides resources for data collection, report management and data correction. Data are collected in the following areas: enrollment / disenrollment; health; functional status assessment; service utilization; inpatient utilization; and informal supports.

Data are used for the following purposes:

- to prepare reports on participant characteristics for the Centers for Medicare and Medicaid Services, state Medicaid agencies, researchers and others
- to enable PACE programs to engage in cross-site data analyses and benchmarking and to monitor the progress of the model as it matures

The National PACE Association uses the DataPACE data to create the PACE Profile as well as provide cross-site comparisons for organizations to benchmark their data. PACE Vermont will enroll in the DataPACE program. PACE Vermont will agree to provide resources for data collection, report management, and other matters pertaining to the integrity of the PACE Minimum Dataset. The National PACE Association will agree to provide software, manuals, technical support and continued training. Data are monitored by the National PACE Association for quality and completeness.

PACE Vermont Program Development & Implementation Plan

PACE Vermont was incorporated as a Vermont domestic non-profit corporation in December 2003 and is the result of two long-term care coalitions joining forces to create a collaborative approach to governing and administering two PACE Centers under one PACE program to serve frail elderly Vermonters. The new Coalition includes the Champlain Long-Term Care Coalition (which serves Chittenden and Southern Grand Isle Counties) and the Rutland Long-Term Care Coalition (which serves Rutland County). The coalition has active representatives from key organizations providing senior housing, home care and hospice services, skilled nursing care, inpatient and outpatient hospital services (a tertiary academic medical center in Chittenden County and a large community hospital in Rutland County), senior center services, transportation, mental health

care, vocational rehabilitation, adult day programs, AAA services, and physician services. Other community representatives also participate in the coalition.

The partners in the two coalitions have elected a transitional Board of Directors for the new corporation that will serve for two years. This will enable the PACE staff and program to capitalize on the expertise and in-kind support services of the partners in several areas. For example, Fletcher Allen Health Care will provide claims processing and accounting functions through their managed care company, while the Rutland Visiting Nurses Association will provide marketing support. All partners within the Coalitions will be key in promoting the PACE philosophy and in identifying potential participants. The time and expertise provided by all of the partners serving on committees and task forces have furthered, and will continue to further, the achievement of program goals during the development and start-up period. PACE Vermont anticipates subcontracting for other services from other coalition organizations. These subcontracting arrangements will be completed prior to submission of the PACE Application.

In summary, the partners in the two coalitions have extensive experience and have a demonstrated commitment to improving services for frail older adults. With their leadership and expertise in working with this population, and with the state and federal Medicaid and Medicare reimbursement and regulatory systems, PACE Vermont anticipates being able to enroll over 60 participants in each location within the first three years and expects to enroll over 120 participants in each location within five to seven years. In order to reach persons in the state's most remote areas the program will invest in transportation and technology linkages for the PACE program.

Application Process

Vermont has previously submitted a state Plan Amendment to CMS and received approval to offer PACE as a service. In 2004, the Vermont General Assembly appropriated $100,000 in start up funds for PACE Vermont. PACE Vermont has also received $20,000 from the Vermont Community Foundations, $80,000 from the James T Bowse Community Health Trust grant, and is pursing other private foundations for additional funding. In addition, $744,000 was earmarked in legislation for the program by Senator Jeffords.

PACE Vermont is working with the state and Palmetto Health to finalize its application and will submit it to CMS in the summer of 2005. It is anticipated that the readiness review will be conducted by the Department of Disabilities, Aging and Independent Living in the spring of 2006. The first participants will be enrolled in July 2006. CMS is expected to conduct a site visit in the summer of 2006.

The application will provide a detailed description of the plan for implementing the PACE program in Vermont. The implementation plan will cover the following items:

- General Information & Organization
- PACE Administration
- Financial Information
- Marketing Plan
- PACE Services
- Participants' Rights
- Quality Assessment & Performance Improvement
- Participant Enrollment & Disenrollment
- Payment Processes
- Data Collection, Record Maintenance & Reporting
- Program Expenditures Reporting

Fiscal Monitoring

Financial information will be maintained by PACE Vermont. The financial records and reports of PACE Vermont will be prepared on a monthly basis using the accrual basis of accounting and conform to GAAP and industry standards. These records and reports will be an accurate reflection of all financial transactions occurring during the reporting period. An independent public accounting firm will audit the financial statements of PACE Vermont on an annual basis. A letter of their findings and recommendations will be issued along with an annual report of financial condition. The annual financial statement will contain a statement of operations, balance sheet, changes in fund balance, and a statement of cash flow. PACE Vermont will submit quarterly financial reports to the state documenting actual expenditures.

A separate Medicaid Eligibility Group (MEG) will be used to track and report expenditures under the demonstration for individuals enrolled in PACE Vermont.

In addition, as part of the cost analysis, actual utilization of services will be monitored. Utilization information will be gathered through DataPACE. This will include census; percentage of enrollees needing help with ADLs; and utilization of inpatient services, outpatient services, day center services, physician services, nurse practitioner, nursing, PT, OT, recreational therapy, social work, personal care, and overnight support. This information will be compared with census and utilization data from other individuals receiving home- and community-based services under the demonstration. In addition, this information will be compared with PACE sites in other states.

Section F: Outreach/Marketing/Education

Prior to the implementation of the demonstration an extensive marketing campaign will be established. That campaign will focus on communicating with individuals currently enrolled in the HCBS programs, existing providers, referral sources and state staff involved in the demonstration. An initial campaign began with a Vermont Interactive Television (VIT) session in April 2005 to review the anticipated time frame for start-up, how the new demonstration program will affect current enrollees; and highlighting changes in eligibility, program benefits, enrollment processes, the delivery of services and the transition from the current 1915(c) HCBS waiver programs. The Department will continue the monthly informational sessions via VIT throughout the implementation stages of the demonstration.

Prior to start-up, a letter will be sent to each participant describing the new program and what effect, if any, it will have on his or her current service plan. In addition, case managers will inform current enrollees of program changes at the time of their monthly contact. The direct contact will permit the accommodation of persons with special needs and those with Limited English Proficiency (LEP). Both interpreter services and bi-lingual materials will be provided within this demonstration on the same basis as is done through the Vermont Health Access Plan Demonstration for persons with LEP.

Brochures, fact sheets and press releases will be the basis of a broad effort to dispense general information. Senior Help Line and the 211 information and assistance line will be utilized as a method for interested individuals to obtain additional information on the new program. The DAIL website also includes information on the demonstration program. Attachment A to this protocol includes "mock-ups" of the informational brochure and other materials developed to-date.

DAIL staff will have the responsibility for conducting outreach to the local community partners, including hospital discharge planners, physician offices, nursing facility admission / discharge staff, residential communities, local advocacy groups, and case managers from the Area Agencies on Aging and Home Health Agencies. DAIL staff will attend local waiver team meetings and other community events to ensure ongoing communication as the program is implemented.

A significant effort will be made to ensure that the discharge planning staff at local hospitals and the admission staff at nursing facilities have a complete understanding of the changes in the Medicaid long-term care service system. DAIL staff will develop a close working relationship with these partners by

attending staff meetings, providing case consultation on referrals, and encouraging the attendance of these individuals at local waiver team meetings.

A comprehensive training packet will be used for the in-depth training of state staff, community partners and referral sources. An outline of this training program is included as Attachment B.

The training curriculum is constructed in three modules. The topic areas are similar; the depth of the content is specific to the audience. The three target audiences are as follows:

- state intake and eligibility staff, case mangers and service providers
- associated community partners and referral sources
- the larger community

Each training packet addresses the scope and depth of information required by each of these three groups to understand the new demonstration program and its parameters.

The general public and potential enrollees will be informed through the media campaign, contact with informed community partners and the availability of informational brochures placed in doctors offices, pharmacies, senior centers, congregate meal sites, and housing facilities.

After the initial, intensive training of state staff, case mangers and service providers, ongoing update training will be offered no less than annually. These sessions will be either a review of the program and its operations or an update on program and policy changes, as necessary.

Specific training will be offered to case mangers and providers regarding the Moderate Needs group with respect to eligibility criteria, service provision and coordination, and reporting under the demonstration.

The Cash and Counseling and Adult Family Care Programs are still in the developmental stages. Plans for information dissemination and training are yet to be developed. It is anticipated that as these programs are ready to be incorporated into the demonstration program-specific marketing and educational materials will be developed and outreach strategies to promote these programs will be implemented.

Funding from a Robert Wood Johnson Foundation grant, which is supporting the Cash and Counseling Program, has been utilized to hire a fulltime Program manager. Polices and procedures, information dissemination, training and the

development of the support systems necessary for implementation of the Cash and Counseling Program are anticipated to be completed by December 2005. The enrollment phase is projected to begin in January 2006. Based on current home and community waiver data supporting consumer/surrogate directed options, it is projected 50 individuals will be enrolled within the first year. It is anticipated 250 individuals will be enrolled in the Cash and Counseling Program by the end of the third year.

Section G: Notification of Program Participants

Current participants in the 1915(c) waiver programs will receive written notification 30 days prior to the implementation of the demonstration of the changes in the home- and community-based services programs. All participants in the existing HCBS waiver programs and those residing in nursing facilities will be automatically enrolled into the demonstration program. The notice sent to inform them about the new program will also tell them that they are being automatically enrolled in the demonstration and that no action is required of them at that time. The notice will also tell them who to call if they have any questions. It will further instruct them to contact their case manager if they have any concerns about their continued provision of services. The notice will include a general description of the new demonstration program. It will highlight the differences between the existing programs and the new program, describe how these changes may or may not affect them, and provide information on who they can contact for further information. A copy of the draft notification letter is included as Attachment C.

Notices will also be sent to individuals who are resident in a nursing facility. That notice will inform them that they may continue to receive services in the nursing facility under the new demonstration. All participants residing in nursing facilities will be automatically enrolled in the demonstration program. The notice sent to inform them about the new program will also tell them that they are being automatically enrolled in the demonstration and that no action is required of them at that time. The notice will also tell them who to call if they have any questions. They, or their family members or legal representatives, may also contact a DAIL staff member with any questions they have, including requests for an evaluation to determine if they might be able to return to the community with home- and community-based support services.

When the auto-enrolled demonstration participants have their next re-assessment, their clinical eligibility status will be re-determined and they will be assigned to the appropriate clinical category (Highest Need, High Need or Moderate Need group) under the demonstration.

Section H: Eligibility & Enrollment

Eligibility Determination Process

Elderly persons and younger adults with physical disabilities who meet the clinical and financial eligibility requirements of the LTC Medicaid program will be enrolled in the demonstration. At the time existing participants in the state's current HCBS waiver programs are auto-enrolled into the demonstration program, enrollment in the 1915(c) programs will cease. Individuals who were eligible under the previous 1915(c) waivers or those who are residing in a nursing facility will be automatically enrolled in the demonstration and will continue to receive the services on their current plan of care. When these auto-enrolled individuals have their next re-assessment their clinical eligibility for the demonstration will continue provided that they meet the clinical criteria for the Highest or High Need groups. This will be the case regardless of the level of funding available for the High Need group.

New applicants will be enrolled in the demonstration if they meet the clinical criteria for the Highest Need group and also meet the financial eligibility requirements for the LTC Medicaid program. New applicants who do not meet the clinical criteria for the Highest Need group but do meet the criteria for the High Needs group (and are otherwise financially eligible) will be enrolled and served through the demonstration to the extent that funding is available.

Moderate Need group applicants must meet the clinical criteria for that group, as well as the financial criteria established for this demonstration program. DAIL has established the following financial criteria for the Moderate Need group:

- Income at or below 300 percent of SSI (includes all sources of income)[3]
- Assets of less than ($3,000 / $5,000 / $10,000 – by phase) shall be disregarded. All assets greater than that amount shall be considered as available income. The value of any "excess" assets shall be converted to a monthly income by dividing by 12

Individuals who meet the Moderate Need group clinical criteria will be identified by local demonstration network providers, including Adult Day, Homemaker, and HASS providers. These providers will also manage the enrollment process for this group by screening for clinical and financial

[3] *Monthly medical expenses (including but not limited to prescription and non-prescription medication, physician, hospital or other medical provider bills, health insurance premiums, copayment or deductible costs paid by the individual, and medical equipment and supplies) are deducted from the individual's gross monthly income to determine their adjusted income for purposes of determining eligibility as a Moderated Need enrollee under this demonstration.*

eligibility. The providers will then arrange for the provision of any of the three covered services for this group that are deemed appropriate and necessary. DAIL will ensure the provision of case management services for the Moderate Needs group. The participants who are receiving HASS services will be case managed by the HASS Service Coordinators. There may be Moderate Needs individuals placed on a waiting list due to a shortage of funding. These waiting lists will be coordinated by the local providers and they will be administered on a first-come, first-served basis. Copies of any waiting list will be provided to DAIL, which will maintain a consolidated list by region.

A detailed description of the clinical and financial eligibility criteria, assessment and re-assessment procedures, and level of care determination processes applicable to this demonstration are included in Attachment D. Attachment D, Part 6 also includes the application for the Moderate Need group.

Resource Limits

Under the demonstration the resource limit for single individuals who own and reside in their own homes will begin at $3,000 and raised in phases up to $10,000 provided funding is available. This will permit individuals to maintain adequate assets to ensure they are able to make any home repairs necessary to allow them to safely remain in their home (e.g., a working furnace, a leak-proof roof, etc.).

Determining Level of Care & the Intake, Assessment & Enrollment Process

For the Highest and High Need group members, DAIL staff will receive referrals from multiple sources in the community (Attachment E includes the referral form). Current assessments, if they exist, will accompany the referral. This will include existing long-term care service assessments, nursing home admission assessments, residential care home assessments, and/or hospital admission assessments. The determination of clinical eligibility will be based upon the referral, assessment, and any other available information. If the information needed to make a determination of clinical eligibility is not readily available, DAIL staff will contact the applicant or their representative to obtain more information and complete a clinical assessment. A face-to-face interview will be conducted, if necessary. If the individual is found clinically eligible, a clinical certification form is sent to the Department for Children and Families/Economic Services Division for a determination of financial eligibility. If the individual is found clinically ineligible, a denial notice with a description of appeal rights is sent to the applicant.

If the case manager and the home-based or Enhanced Residential Care provider believe that the applicant meets the long-term care Medicaid financial eligibility criteria, services may begin immediately after the DAIL clinical certification is made. While the financial eligibility determination is pending, DAIL staff will determine the minimum level of services necessary to maintain the applicant at home. The decision to start services prior to the financial eligibility determination will be made between the provider of service and the applicant. Any services provided during this interim period will be in accordance with an agreement between the provider and the individual or his/her legal representative. The provider may not bill the Medicaid program for long-term care Medicaid services until the Department for Children and Families/Economic Services Division has determined that the individual is financially eligible and DAIL has authorized the Service Plan. If the individual is ultimately found ineligible for long-term care Medicaid services, the provider may bill the individual for any services provided from the date of clinical certification through the date a denial notice was received by the provider.

If the individual elects to receive his/her long-term care services in a nursing facility and the facility believes that the individual will meet the long-term care Medicaid financial eligibility criteria, the facility may start delivering services immediately after DAIL staff provides a clinical certification. The nursing facility provider will inform the individual that admission prior to the final financial eligibility determination may result in a personal financial liability if they are subsequently found ineligible for long-term care Medicaid program.

DAIL protocols document the process and parameters for making clinical and financial determinations for each of the three clinical groups (Highest, High and Moderate Needs). These documents are included as Attachment D. The DAIL staff will be responsible for making clinical and level of care determinations. In cases that are unclear, DAIL staff may also consult with the staff of the Division of Licensing and Protection.

Individuals who elect to utilize nursing facility care for their long-term care needs will initially be screened using the Preadmission Screening and Resident Review (PASARR) instrument. If the PASARR screen results in a determination that the individual may need active mental health treatment, the screener will contact the Department of Mental Health for assistance with further evaluation of the individual.

Once an individual is determined to be clinically eligible for the program, a Long-Term Care Clinical Coordinator (LTCCC) will make a determination as to whether the individual meets the Highest or High Need group criteria. The LTCCC will discuss long-term care Medicaid service options with the individual

as part of the application/assessment process. Individuals may also request additional options information and education by marking that request on their referral form. The LTCCC will assure that options brochures and educational information are available as needed.

As previously discussed, clinical eligibility for the Moderate Needs group is determined at the local provider level based on DAIL criteria.

If the individual is found to meet all of the clinical eligibility criteria, the LTCCC will forward the Clinical Certification Notice (see Attachment F) to the case management agency that the individual selected on the initial referral form. The local case manager will contact the individual and make arrangements for the completion of the Independent Living Assessment. A registered nurse will complete the health assessment portion of the ILA. The case manager will assess the individual's circumstances, resources, program eligibility, and formal and informal support systems. The results of the assessment will serve as the basis for the development of the individual's plan of care. The case manager will conduct a review of service options and discuss any limitations with the individual or their representative. The case manager will, in conjunction with the individual or his/her representative, develop a comprehensive service plan that addresses his/her needs. The participant will review and sign-off on the service plan. The completed assessment and signed service plan will be sent to DAIL for a staff level review. DAIL staff will conduct a thorough utilization review prior to authorizing a new annual service plan. If the individual chooses a nursing facility as their long-term care setting the case manager will assist them in locating a facility, if necessary.

The case manager may also assist the participant in completing any financial eligibility reviews that DCF requires to maintain long-term care Medicaid eligibility if such assistance is requested.

The ILA measures cognitive status as well as functional status. The ILA also assesses mental health status and will provide the case manager with the information needed to develop a care plan to address these needs as well.

Annual Re-Assessments

Participants will have a comprehensive assessment completed on a regular basis. The reassessment procedure is determined by the particular long-term care Medicaid setting in which the individual is served.

For those receiving home-based services, the case manager will complete a re-assessment of the individual using the ILA at least annually and prior to the

anniversary of the participant's admission into the program. The case manager will assess any changes in the individual's circumstances, resources, program eligibility, and formal and informal support systems since the time of the original assessment or last re-assessment. If needed, an RN will complete a re-assessment of the individual's health condition.

The case manager will also conduct a review of any new or more appropriate service options that should be considered with the individual or their representative. The case manager will modify the comprehensive service plan, as appropriate, in conjunction with the individual or their representative. The participant will review and sign-off on the revised service plan. The completed re-assessment and signed service plan will be sent to DAIL for a staff level review. DAIL staff will conduct a thorough utilization review prior to authorizing any modifications to the annual service plan.

For participants residing in an Enhanced Residential Care (ERC) facility, the residential home care provider will complete a comprehensive reassessment or RCHRAT (See Attachment G). Annually, prior to the end of the current annual plan of care, a registered nurse must complete a reassessment. The ERC provider will send a copy of the RCHRAT to the participant's case manager. The case manager will complete an ERC tier worksheet and ERC service plan. The participant will sign the revised service plan and the case manager will submit the completed re-assessment packet to the LTCCC for utilization review and acceptance.

For individuals residing in nursing facilities, the nursing facility provider will continue to complete the Minimum Data Set or MDS according to current federal and state nursing facility regulations.

Re-assessments are required annually for home-based settings, at a minimum, and prior to the anniversary of the participant's enrollment. Re-assessments are also conducted when there is a significant change in the individual's condition, as identified by the participant, case manager, a Long-Term Care Clinical Coordinator, or for any other reason identified by a DAIL staff member. Individuals who reside in nursing facilities will be re-assessed when triggered during the utilization process.

Disenrollment

An individual may voluntarily withdraw from participation in the long-term care Medicaid program at any time for any reason. The individual will inform the case manager or provider of their decision to withdraw. A change report

form will be completed by the case manager or provider and submitted to DAIL and DCF indicating the reason for termination and that it is voluntary.

Applicants may be denied eligibility and active participants may be terminated from the long-term care Medicaid program for any of the following reasons: clinical ineligibility, financial ineligibility, death, permanent move out of state, or a temporary out-of-state move that exceeds 30 continuous days, or in circumstances in which DAIL is not able to assure the individual's health and welfare. A Change Report form (see Attachment H) must be submitted to DAIL as notification of participant termination in all cases.

Determining Existence & Scope of Applicant's Third-Party Liability

The existence of third-party liability will be determined as part of the financial eligibility processes for those in the highest and high needs group. At the time of application for long-term care Medicaid, an applicant is required to provide information about any other private health insurance. The Department for Children and Families / Economic Services division obtains the name, address, group and policy number, type of coverage and names of persons covered. If an applicant fails to disclose this information Medicaid will be denied.

Implementing Consumer-Directed Services

Vermont has had a long history of utilizing consumer- directed services. Currently, 45 percent of participants are receiving consumer or surrogate-directed services throughout the state. The state anticipates that this will continue to be a popular option under the demonstration.

Case mangers are trained in the nuances of consumer and surrogate-directed services and are competent in assisting participants in operationalizing this option. A consumer and surrogate-directed services employer handbook has been developed which offers detailed guidance on the roles and responsibilities of an employer (See Attachment I).

Under the demonstration, the consumer and surrogate-directed services option is available statewide. Over the course of the five-year demonstration period the state anticipates that the use of this option will be expanded by approximately 65 percent. See Section M of this document for more information on the consumer and surrogate-directed option.

Allocating Cash Allotment to Participants for Self-Directed Services

Individuals who choose to enroll in the self-directed Cash & Counseling will receive an independent functional and clinical assessment. The state will use the assessment to determine the cash value available to the individual. After establishing the cash value for the plan, the individual will then be able to choose a consultant. The consultant will work with the individual to develop an individualized spending plan. The program plans to allow the distribution of cash to consumers for items or services that cannot be easily invoiced.

Section I: Enrollment Limit

Individuals currently receiving long-term care Medicaid services who meet the clinical criteria for Highest Need or High Need groups and the financial criteria for LTC Medicaid services will be enrolled in the demonstration and services will continue to be provided to these individuals on an entitlement basis.

New applicants who meet the clinical criteria for the Highest Need group and the financial eligibility standards for LTC Medicaid will also be similarly enrolled and served through the demonstration. However, for new applicants who meet the clinical criteria for the High Need group and the financial criteria for LTC Medicaid, services will be started if funding is available. These individuals may be placed on a waiting list for services if adequate state and federal funds are not available at the time of their eligibility determination.

The waiting lists for each area of the state will be maintained by each of the local DAIL Long-Term Care Clinical Coordinators (LTCCCs), and managed in conjunction with the local waiver teams. A wait list sheet will be used when there is a need for a waiting list for services for individuals who meet the High Needs clinical criteria, but for whom no funding is available. The protocol and priority score sheet is included as Attachment J to this protocol. Individuals will be scored using the High Need wait list tool which identifies their status by category. Based upon the individual's score, his/her priority position on the list will be determined. Enrollment into the demonstration and the provision of services will be begin in order of priority category (e.g. category #1 will always have the highest priority and those individuals will be enrolled and served first).

The waiting lists will be reviewed monthly at the waiver teams' regular meetings. Case Managers will be charged with maintaining contact on a monthly basis with individuals on the waiting list to inform them of their status.

Moderate needs individuals will be served to the extent funding is available for this group. These individuals are only eligible for a limited package of home- and community-based services. Waiting lists will be maintained at the local provider level if there are not adequate funds to serve everyone who meets the clinical and financial eligibility criteria for the Moderate Needs group. Individuals with Community Medicaid will have priority. Otherwise waiting lists will be administered on a first-come, first-served basis. See Section K for more information on the benefit package for this group.

There are no pre-set limits on enrollment. Vermont fully intends to serve more people in need under this demonstration than was previously the case. However, funding constraints may result in some persons with lesser needs having to wait for funding to become available before they can be served.

Section J: Restricting Providers

This portion of the demonstration design relates to the state's process for contracting for nursing facility bed days. Selective contracting for nursing facility bed days under the demonstration is on hold at this time. Should the state decide to implement selective contracting for nursing facility bed days in the future, DAIL will develop a process and criteria for selecting the nursing facilities and an allocation method for Medicaid reimbursement, all of which will be subject to CMS review and approval. The criteria used for any selective contracting process will be consistent with the requirements of Section 1923 of the Social Security Act and with respect to access, quality, and efficient and economic provision of care and services.

Should the state decide to move forward with selective contracting, DAIL will also submit to CMS, for its review and approval, provider contracts, any legislative provisions governing the selective contracting process, as well as a description of the public notice process.

In the interim, Vermont will continue its current process for contracting with nursing facilities for bed days.

Section K: Covered Benefits under the Demonstration

Description of Amount, Duration & Scope of Services for Each Demonstration Group & Interface with Other Services

Individuals found eligible for full Medicaid benefits will have access to all Medicaid covered acute care services in the same manner as they do under the current program. This section of the Operational Protocol describes the long-term care benefits available to demonstration participants.

Services are available in the home- and community-based and institutional (nursing facility) setting for individuals in the Highest and High Need groups. Home-based and Adult Family Care services include case management, personal care, adult day care, respite care, companion services, personal emergency response systems and assistive devices and home modifications.

Services provided to individuals in Enhanced Residential Care (ERC) settings are bundled into a daily rate for the facility. The services provided in the ERC setting include case management, nursing overview, personal care services, medication management, social and recreational activities, 24-hour supervision, meals, laundry, and housekeeping services.

For individuals served in a Nursing Facility setting the services include 24-hour skilled nursing, specialized rehabilitation therapy, personal care, medication management, meals, social and recreational activities, 24-hour supervision, laundry, housekeeping, nutritional services and social services. These services are reimbursed through a bundled daily payment to the nursing facility.

Persons who meet the clinical criteria for the Moderate Needs Group will be eligible for case management, adult day care and homemaker services only. The actual level of services provided will be dependent on the funding available for this group.

There are two types of Personal Care Service providers; both types of providers render assistance with Activities of Daily Living (ADLs) such as eating, medication management, dressing, walking, transferring, toileting and bathing. Instrumental Activities of Daily Living (IADLs) such as cooking, cleaning, and shopping assistance may also be provided. Services may be provided by home health agencies or by attendants hired, trained and supervised by qualified consumers or their surrogates. This includes attendants who are qualified spouses providing personal care under the demonstration.

Long-Term Care Service Descriptions

Following is a brief description of the long-term care services available to participants in the demonstration.

Personal Care Services include assistance with Activities of Daily Living (ADLs) like eating, dressing, walking, transferring, toileting and bathing. Instrumental Activities of Daily Living (IADLs) such as cooking, cleaning and shopping assistance may also be provided. Services may be provided by regional home health agencies or by attendants hired, trained, and supervised by qualified consumers or their surrogates. Under this demonstration Vermont will expand the use of relative caregivers on an compensated basis to include spouses. The state will make the determination as to whether the spouse is able to provide the personal care services included in the enrollee's care plan and is also the best provider to do so.

Respite Care may be provided in home settings, adult day centers, residential care homes or in nursing facilities to relieve primary caregivers.

Companion Services include non-medical supervision and socialization. Companions may assist or supervise with tasks such as meal preparation, laundry and shopping; however, these tasks are not provided as discrete services. Companion services do not include hands-on personal care. Companions may perform light housekeeping tasks which are incidental to the care and supervision of the individual. Individuals providing this service must be high school graduates or the equivalent, 18 years of age or older and have training and skills that are specific and adequate to meet the needs of the participant.

Adult Day Services are community-based, non-residential services designed to assist impaired or isolated participants in remaining active in their communities while ensuring the health and independence of the individual. Services include a range of health and social services for participants and provide respite for primary caregivers. Services are furnished for a specified number of hours per day on a regularly scheduled basis, for one or more days per week.

Personal Emergency Response Systems include electronic devices which enable individuals at high risk to secure help in an emergency.

Assistive Devices and Home Modifications include items used to increase, maintain or improve functional capabilities and independence in performing ADLs or IADLs. Home modifications may include physical adaptations to the home which are necessary to ensure the health and welfare of the participant and

which maintain, increase or improve functional capabilities and independence. This may include ramps, door widening, grab-bars and modification of bathroom facilities, etc., However, this service does not include repairs, maintenance or new construction. Physical adaptations in the home are limited to $750 per year per participant.

Enhanced Residential Care Home Services are a bundled package of services provided by an approved Level III Residential Care Home (RCH) or an Assisted Living Residence (ALR). In addition to services provided to all RCH / ALR residents, these residential settings also provide a Registered Nurse on-site for a minimum of one hour / week and an average of two hours of personal care services per day per participant. Daily social and recreational activity opportunities are also provided.

Nursing Facility Services include care provided in a licensed nursing facility.

Case Management Services include assisting participants in gaining access to needed long-term care Medicaid services and other state plan and community services. The case manager is responsible for the ongoing monitoring of the provision of services included in the service care plan. The case manager performs necessary assessment and reassessments of the individual's needs and reviews plans of care at least annually (or more often if needed) to respond to changes in conditions or circumstances.

Homemaker Services include assistance with house cleaning, food preparation and clean up, and shopping for individuals who do not otherwise require personal care services.

Home-Delivered Meals include the provision of a meal(s) to an enrollee's residence.

Other Living Arrangements includes support for alternative living arrangements such as activities in residential care or assisted living residences, and other supports for home sharing, Home and Supportive Services (HASS) and adult foster care.

Bed Hold/"Leave" Days includes payment for a limited number of days when the enrollee is away from the ERC home due to an inpatient admission or for the purpose of a "home visit".

Two other service options are currently under development: Cash and Counseling and Adult Family Care.

The scope and duration of services are documented in the tables included in Attachment K to this Operational Protocol. As part of the assessment process, the case manager will determine what needs can be met through existing state and community services. Services are limited to those needed to support the individual based upon their assessed needs and the care setting of their choice.

All program participants in the home- and community-based setting will receive case management services. This service will ensure that participants are fully engaged in the development of their care plans and their receipt of needed services. Case management will assist consumer-directed participants in their role as employer, and ensure that systems are in place for back-up or emergency needs, maximizing non-demonstration services and informal systems of care.

The Department of Disabilities, Aging and Independent Living is the designated state agency for administration of the Older American's Act. In that role, DAIL is responsible for the supervision of the case management providers (Area Agencies on Aging and Home Health Agencies) who are intimately involved in and aware of the scope of community services available. A referral tool is used to facilitate the identification of other organizations and programs that the applicant is currently involved with and/or may benefit from. The Independent Living Assessment tool also takes into account what other services may be provided in lieu of, or in conjunction with, the long-term care Medicaid services. In this way DAIL assures the development of a comprehensive service plan for the individual. This will also be the case for services provided to individuals with state-only grant funds.

Community Rehabilitation and Treatment (CRT) services are provided to adults with serious and persistent mental illness in accordance with the terms of the state's Section 1115 VHAP/CRT demonstration waiver. For individuals served under the long-term care demonstration, expenditures for CRT services will remain under the CRT waiver for budget neutrality accounting purposes. The two programs will collaborate on the provision of care for the small number of individuals dually served through both demonstrations. Program reporting will also separately account for CRT expenditures versus all other expenditures (see Section D) for those served through both programs.

PACE Vermont will be also administered by the Department of Disabilities, Aging and Independent Living. Expenditures (capitation payments) for these enrollees will be separately tracked and reported under the demonstration.

For nursing facility residents, the Medicare Advocacy Project (MAP) program will ensure that Medicare benefits and covered services are utilized prior to

accessing payment under the long-term care Medicaid program. The Protocol for this process is included as Attachment L to this protocol.

Relative Caregivers

Under the current 1915(c) Home- and Community-Based Services waiver, family members, except for spouses serving as caregivers, are allowed to be paid as personal care attendants for waiver enrollees. This option, and the oversight of this option, will remain in place under the demonstration. Over the course of the demonstration, DAIL will also establish the parameters under which the family member personal care attendant policy will be expanded to include spouses. The Department will gather input from participants who would like to hire their spouses as attendants, and from the case managers who have knowledge of the participant's family situation. DAIL will put together a study group that will evaluate the advantages and disadvantages of such arrangements and inquire about the experience of other states that have implemented this option within their programs.

As a base of information, the state's current "Employer / Agent Certification Form " (See Attachment M) will be modified to better fit the question of the suitability of a spouse as the attendant. An evaluation of the individual will include the following components: communication skills and decision making abilities; legal status beyond spousal relationship (e.g., Power of Attorney, legal guardian); knowledge of the participant's disability and related conditions; knowledge of personal assistance needs; willingness to work with other providers of care; and employment status (outside of the home). Other areas of discussion will focus on what services are traditionally provided as a result of the spousal relationship and would not be supported financially by the waiver (e.g., preparing meals for both).

Person-Centered Planning

Vermont has more than a 20-year history in managing consumer and surrogate-directed options for elders and younger disabled adults with physical disabilities.

The state has recently received a Robert Wood Johnson Foundation grant to develop the infrastructure for a Cash and Counseling program. This program will offer an additional option for long-term care Medicaid beneficiaries. Consumers will have more options and greater personal autonomy in how to best meet their own care needs. The program allows participants greater flexibility in purchasing non-traditional Medicaid services.

Person-centered planning will be dependent upon the participant's family situation, the support of friends and other community members, as well as other service providers. The individual, together with an identified team, will determine which of his/her needs can be met with the existing available services. Planning will then focus on the gaps in available services versus the participant's needs. It will be a collaborative process in which participants are assisted in accessing the supports and services they need, based on their own preferences and values. During outreach, participants will use a self-screening tool (to be developed) to educate themselves and evaluate the appropriateness of self-directed services and their ability to manage their own care. Participants will make the decision to voluntarily enroll in the Cash and Counseling program. After making this decision, participants will work with program consultants. These consultants will utilize the functional and clinical assessment data and work with the participant to develop an individualized spending plan. The requirement is that the goods and services be related to the participant's identified needs and their successful functioning in a community setting.

Section L: Quality Management

Overview of QM Activities

The Department of Disabilities, Aging and Independent Living (DAIL) is putting in place a multi-faceted Quality Monitoring and Management (QMM) program for this long-term care demonstration. The state's quality management program for this demonstration is described in this section of the protocol.

DAIL is the recent recipient of a CMS Quality Assurance / Quality Improvement Real Choices award, which will assist the state in developing a more comprehensive and complete quality assurance program. The structure for the quality management program reaches across all of the existing waiver programs within the department. This program is currently in the design stage and the quality management process described below may be modified as that program evolves.

The current quality management program encompasses a range of activities that include the following:

- review and approval of all plans of care for demonstration enrollees
- other desk monitoring activities conducted by DAIL staff
- tracking of the services actually provided versus those included in the care plans
- on-site provider surveys
- on-site participant visits
- ongoing case manager certification process
- consumer satisfaction surveys

The quality indicators established for the demonstration contain universal provider standards that are applied to all providers of services and service specific standards which address the particular elements unique to each service and its delivery. A complete description of these standards can be found in Attachment N.

The Division of Licensing and Protection conducts an annual survey of the Home Health Agencies on a rotating basis. The survey results are shared with the Division of Disability and Aging Services for review and follow-up as needed.

The Area Agencies on Aging case managers must be certified and are required to attend periodic training to ensure they retain the knowledge necessary to adequately serve the demonstration population. The Department also monitors how case managers are incorporating their decision-making skills into service plans for participants through several review methods.

On a day-to-day basis, the LTCCCs will be overseeing the assessment process and, as the lead persons for the waiver teams, will be familiar with the issues impacting service delivery. The LTCCCs will be responsible for ensuring the success of this demonstration from a clinical perspective on a day-to-day basis.

DAIL program standards require case managers to have at least monthly contact with participants. This practice helps instill a certain degree of confidence in the safety and welfare of the participants. Complaints of abuse, neglect and exploitation are investigated in-house and then referred to Adult Protective Services, a unit within the Division of Disability and Aging Services, or the Medicaid Fraud Unit for follow-up.

As a matter of policy, the Department conducts background checks for caregivers that are employed through the consumer and surrogate-directed programs. Details of this process are presented in Section M: Self-Directed Supports.

DAIL contracts with Vermont Legal Aid for Ombudsman services for residents in nursing facilities. Under the demonstration, DAIL will expand this contract to include Ombudsman services for all individuals served through the program. This will ensure that all program participants have access to an independent entity responsible for representing their interests.

Utilization Review (UR)

The local DAIL LTCCCs will make all Level of Care determinations. The process consists of a review of assessment documents and follow-up phone calls and face-to-face interviews with applicants, as necessary. With the state staff making the initial Level of Care determinations, DAIL will ensure a more consistent application of the standards used for decision-making. The overall objective of the DAIL clinical oversight processes is to ensure that the services included in care plans are appropriate, both in scope and volume, relative to the identified needs of the individual participants in the demonstration.

Periodic review by the DAIL central office staff of the LTCCCs determinations will be put into place. This practice will provide a second level “check and balance” system for the oversight of LTCCC decisions.

Following is an overview of the basic steps undertaken by DAIL staff during the UR process with respect to services provided in the home-based and ERC setting.

Review Process for Participants Receiving Care in a Home-Based or ERC Setting:

1. DAIL staff reviews documents for completeness, including all necessary signatures by the case manager, the consumer or legal representative and the surrogate (when applicable).
2. DAIL staff reviews the assessment information, with particular emphasis on health and functional needs.
3. DAIL staff reviews the proposed Service Plan, personal care worksheet (home-based), Tier worksheet (ERC) and service volume.
4. DAIL staff document any concerns or actions on a UR form, including conversations with case managers or providers.
5. DAIL staff follows-up with case managers or service providers regarding any questions or concerns.
6. DAIL staff considers variables such as, but not limited to:
   - → health status of the individual
   - → functional needs of the individual
   - → total number of people living in the individual's household
   - → size of the living environment
   - → utilization of other LTCM services (such as adult day services in the home-based setting)
   - → utilization of non-LTCM services, including paid and unpaid help (such as Medicare home health services or family)
   - → variance requests submitted by the case manager
7. DAIL staff shall make adjustments to the Service Plan, when appropriate, according to LTCM eligibility requirements, service principles, definitions, standards and limitations.
8. DAIL staff shall notify the case manager when a Service Plan is being adjusted (if appropriate).
9. DAIL staff will send a copy of the adjusted Service Plan to the individual and providers, including appeal rights.

Following is an overview of the basic steps undertaken by DAIL staff during the UR process with respect to services provided in the nursing facility setting.

Review Process for Participants Receiving care in a Nursing Facility Setting:

This utilization review (UR) plan is for the use with all Vermont long-term care Medicaid recipients who apply for initial admission to a nursing facility, or who reside in Vermont nursing facilities, and for all Medicaid recipients who may be residing in a Vermont Medicaid approved facility outside the state.

Admission to a Nursing Facility (NF) (Coverage)

1. DAIL staff shall review documents for completeness, including all necessary signatures by the case manager, the consumer or legal representative, or the surrogate.
2. DAIL staff shall review the assessment information, with particular emphasis on health and functional needs.

Continued Stay

Using the procedures and format specified by the state, each resident is periodically assessed and classified into the Medicaid case mix system based on the results of the comprehensive assessment. If the resident is classified into one of the case mix categories deemed by the state as automatically meeting NF criteria a continued stay is approved. If the resident does not automatically meet the eligibility criteria, the following procedures will be used:

→ On a quarterly basis the Division of Licensing and Protection (DLP) will generate a facility roster that will identify current residents who, because of their case mix classification, may require review for continued stay eligibility. DLP will provide the information to the appropriate regional RN case manager. The RN case manager will review the facility list of affected residents to determine if any resident on the list requires a LOC review. If it is deemed a review is necessary, the RN case manager will contact the facility, identify which residents are in need of LOC review and conduct the review. The review process will include collecting information on the resident's most current Minimum Data Set (MDS) assessment and any other pertinent current or historical information regarding functional status, medical condition that is relevant to the resident's need for nursing home placement. If, based on the LOC review, the resident is determined to meet the eligibility criteria for nursing facility placement and the needs of the resident can be most effectively met in a NF, a continued stay is approved. If it is determined that the individual does not meet the eligibly criteria for continued NF placement or that the needs of the individual can not be most effectively met in the NF, the continue stay will be denied in accordance with the procedures described below.

Continued Stay Denials

1. When the RN Case Manger has determined that the NF resident is no longer eligible for NF placement the following will occur:

   → The RN Nurse Manger will inform the facility administrator or designee that the resident is not eligible for continued NF placement and request that discharge planning be initiated.

   → If the facility does not agree with the determination, the NF has the opportunity to discuss the reasons why they disagree and submit additional information for consideration. The RN Case manager, prior to making an eligibility determination, will consider all additional information regarding the residents care needs, safety factors, risk factors, psychosocial needs, or other pertinent information.

2. If the facility does not agree with the determination based on the review of additional information the next steps will occur:

   → The RN case manager will conduct an on-site visit to the facility to observe and evaluate the resident's functional and medical status.

   → The RN Case Manager will contact the resident's attending physician to obtain historical and current medical information before a final determination of the individual clinical eligibly is made.

3. If the RN Case Manger determines that the resident is not eligible for NF placement, the facility and the resident will be informed, in writing, within two working days that the resident is not qualified or eligible for continued nursing home placement. The following steps are taken:

   → Denial Letter: An original of the denial letter is sent to resident and or his / her legal representative, with a copy to both the attending physician and the facility.

   → DCF Notification: A notice is sent to Local DCF office with a copy to the facility, resident (and / or legal representative), and the attending physician.

No Appropriate Placement Available (NAPA)

When either a resident's continued stay has been denied, or the attending physician has written a discharge order and no appropriate placement is available, the resident will be placed on NAPA status. DAIL will monitor discharge planning activity regularly until discharge occurs.

Monitoring Program

The Department has several methods for ensuring that the Level of Care decision-making process is appropriately correlated with the participant's service needs, particularly with respect to the development of the Plan of Care. The LTCCCs will be responsible for the ongoing review, approval, and monitoring of the care plans for each program participant. The focus of their review will be centered on the inclusion of an array of services that are clinically appropriate given the individual's unique set of circumstances and any health and safety risk factors, and that the plan addresses the individual's personal goals. They will also ensure that the amount, duration and scope of services is adequate to meet the individual's needs and that, to the greatest extent possible, the individual's freedom of choice of provider is maintained.

DAIL tracks the contents of all care plans and compares the actual utilization of services by the participant to those services included in the care plan. Other standard monitoring practices include reviews of case management records; interviews with program participants, surrogates and other related individuals; and a comprehensive complaint monitoring system that includes verification of the complaint, fact finding, resolution and data analysis.

Comparative analyses will be conducted across the Plans of Care developed by the Area Agencies on Aging versus those prepared by the home health agencies. These comparisons will examine the degree of variability among the plans across like populations. Where plans are deemed to be inadequate, a corrective action plan will be required and closer monitoring will be done specific to the individual case manager. Data analysis will be used to further assess the content of the Plans of Care through the DAIL database system. This system enables the Department to compare and contrast the care plans developed by different agencies across like populations. This system will also be used to monitor the quantity of services provided on an individual and aggregate basis for each of the regional case management organizations.

Certification of Case Managers

All providers are required to meet DAIL's licensing and certification requirements or established standards. DAIL has the primary responsibility for ensuring appropriate licensure and certification of all providers. The staff in the DAIL central office is responsible for monitoring provider status. Non-licensed, non-certified providers are also required to meet certain standards established by DAIL (see Attachment I – Employer Handbook). Any provider found to be out

of compliance will be notified of the required corrective action to continue as a demonstration provider.

All case managers must be certified by the state. Certification standards include a requirement to complete 20 hours of professional development education and an annual training program. Certification remains in effect unless revoked by DAIL. Revocation will occur when there is clear evidence that quality case management services, consistent with DAIL Case Management Standards, are not being provided and/or professional development and training has not been maintained. If a determination is made that an individual case manager is not otherwise performing up to state standards, a discovery and remediation system is activated.

Fiscal Integrity (non-duplication of payments)

The Vermont Agency of Human Services, AHS, will ensure through its Medicaid Management Information System (MMIS) and its claims processing contractor (EDS) that there is no duplication of payments for services rendered through the various Medicaid waivers and programs. The MMIS contains logic to identify duplicate claims, regardless of the funding source/program, thereby preventing duplication of payment.

The MMIS maintains a "Demographic Modifier" table that is used to match Medicaid enrollees to specific programs, including the VHAP 1115 Waiver, CRT, PACE and the Choices for Care 1115 Waiver. The Demographic Modifier table includes the recipient id and the start/end dates for enrollment in these specialized programs. The Demographic Modifier logic enables the system to assign payment responsibility to a specific funding source, as well as maintain other edits. For example, if a claim is submitted for a service provided while an individual is enrolled in the (capitated) PACE program, the claim will be denied.

The MMIS has the capacity to maintain multiple Demographic Modifiers for the same eligibility record. For example, an individual could be simultaneously enrolled in the CRT Waiver and the Choices for Care Waiver. In these cases, the logic will incorporate a hierarchy to ensure that the payment responsibility is assigned to the appropriate program.

With regard to services that are reimbursed outside the MMIS, the state relies on a number of other reporting and monitoring tools to prevent duplicative payments.

The Medicaid program and the Department of Aging and Independent Living have policies and procedures to ensure that financial reporting and monitoring

for non-Medicaid funded programs, such as the Older Americans Act, are coordinated with Medicaid funded programs. The Medicaid Provider Participation Agreement prohibits providers from billing Medicaid (as the payor of last resort) for any service that has been reimbursed or funded by another source. The state's Medicaid Fraud Detection Unit monitors compliance with this requirement through periodic claims reviews and provider audit activities.

As the administrator of federal grant programs, the Department monitors provider activities to ensure that providers are meeting contractual obligations with regard to service delivery and reporting. Agreements with providers specifically identify the types of services that may be supported with grant funds. The Department monitors compliance through periodic reviews of providers' service reports, financial reports, and individual case files.

Financial monitoring exists on several levels. The Director of the Department's business office reviews the A-133 Audit and conveys to the Division staff any identified areas noted for correction and appropriate action. The business office issues a monthly monitoring report to appropriate personnel that compares actual expenditures to planned expenditures, and provides an assessment of any over or under payments. This report is reviewed by DAIL management on a monthly basis and programmatic adjustments are made as necessary.

Oversight and monitoring of the Intermediary Service Organization (ISO) for employer support services within the consumer and surrogate-directed services program is conducted via monthly meetings and through data submission and claims review (See Section M).

Section M: Self-Directed Supports – Education, Counseling, Fiscal Intermediary & Support Services

The State of Vermont has a long history with self-directed supports for individuals accessing personal care, respite and companion services. The existing system will be maintained under the demonstration.

Program participants are counseled at the time of enrollment about the three options through which they may have their services delivered: consumer directed, surrogate directed and agency directed. The consumer-directed model establishes the participant as the employer of their Personal Care Attendant (PCA) with all the rights and responsibilities of an employer. The surrogate-directed option allows the participant to appoint another person to act as his/her agent and the employer. The agency-directed option provides all services through an appropriate home health agency.

Access to the self-directed support option is offered through the individual's case manager. The case manager is also responsible for assisting the individual in understanding the obligations and limitations of this service utilization option. An employer handbook (See Attachment I) is made available to participants at the time they are determining whether this is how they want to have their services delivered. Services available under this system are limited to personal care, respite and companion services.

All consumers must be screened as to their ability and willingness to direct their own care prior to being approved for this option. Eligibility guidelines include the ability to understand and perform the tasks required to hire a caregiver and the ability to communicate effectively with the case manager and caregiver in performing the tasks required of the caregiver. If an individual does not meet the criteria for consumer-direction, they may be offered the option of selecting a surrogate to act as an employer agent on their behalf. All consumer or surrogate-directed employers are verified and documented by the case manager as to their competency. The case manager is charged with the responsibility to monitor the employer's ongoing abilities during the monthly contacts and at the time of the annual reassessment.

If an individual or surrogate is deemed to no longer be able to act as the employer they are notified in writing by the case manager. At that time they are offered the option of continuing their services through the agency directed option.

The Intermediary Service Organization (ISO), which provides employer support services for this program, is enrolled with Medicaid as a provider and has a written contract with the Agency of Human Services to provide those services (See Attachment O). The state currently contracts with one payroll agent (ARIS) to provide employer services for consumer and surrogate-directed services. This contract delineates the scope of services to be performed, the terms and conditions of the agreement, reporting mechanisms, payment methods, and oversight requirements. The contract is competitively bid every three years.

Consumer or Surrogate employers and their employees (Personal Care Attendants) must enroll with the ISO, including filing all employment forms as required by law. Personal Care Attendants do not enroll directly as Medicaid providers. This is a continuation of DAIL's current process.

The ISO is evaluated at least annually during the term of the contract and is monitored monthly. The evaluation may include an assessment of cost-effectiveness, access, communication with participants, ability to meet payroll and non-payroll goods and services payment schedules, ability to process payment requests promptly, timeliness of applicable federal and state payroll reporting requirements and other relevant areas of performance.

Background checks are performed on behalf of the employer by the ISO. Background checks include information on any complaints of abuse, neglect, and exploitation made to the Department of Children and Family Services or the Division of Licensing and Protection. A request for information on criminal convictions is made to the Vermont Crime Information Center. References are also obtained from previous employers and others who can provide character references for the prospective employee.

Section N: Participant Protection for Self-Direction

The Department of Disabilities, Aging and Independent Living has developed a comprehensive approach to ensuring the viability and appropriateness of its consumer and surrogate-directed services programs.

At the time of application, case managers provide all potential recipients of home and community-based services with information on their service options, including consumer or surrogate direction of services. Those who express an interest in this service delivery option are evaluated to determine if the consumer or surrogate meets the criteria for performing this function. Those who may meet the criteria are given further information, via the state's Consumer and Surrogate Directed Services Handbook (see Attachment I) which covers all aspects of the program and the individual's responsibilities as an employer.

Additionally, Vermont contract with an Intermediary Services Organization (ISO) to provide employer support services and technical assistance. ISO services include enrolling employers and employees into the payroll system, processing timesheets, issuing payroll checks, processing taxes and withholding in accordance with state and federal law, processing workers' compensation claims, and unemployment benefits.

If at any time a case manager determines that an individual or his/her surrogate is unable to continue as the consumer or surrogate director, and an alternate surrogate cannot be identified and trained, the individual will be enrolled in agency directed services.

Section O: Financial Incentives for the Purchases of Long-Term Care Insurance by Individual Vermonters

The Department will create a workgroup during the first year of the demonstration, led by a member of the Department of Children and Families Economic Services Division, to evaluate options for providing financial incentives for the purchase of long-term care insurance. Current plans for the membership of the workgroup include representatives from:

- ✓ Division of Health Care Administration
- ✓ Division of Disability and Aging Services
- ✓ Division of Economic Services
- ✓ American Association of Retired Persons
- ✓ Long-Term Care Ombudsman
- ✓ State Health Insurance Program
- ✓ Elder Law Committee of the Vermont Bar Association
- ✓ Long-Term Care Insurance Brokers / Carriers

During the second year of the demonstration, the workgroup will explore strategies for implementing options for providing financial incentives for the purchase of long-term care insurance as identified in the first phase of planning. It is expected the financial incentives to be further evaluated will include:

- Incentives for blended life / annuity policies
- Incentives for reverse mortgages
- Incentives for creation of group policies by employers
- Partnership policies. This strategy is currently obstructed by OBRA 1993, which contained language that has a direct impact on the expansion of partnerships for long-term care. States seeking new partnership strategies must abide by the conditions outlined in OBRA '93, including the following:
  - → Section 1917(b) paragraph one subparagraph C: requires any state operating a partnership program to recover from the estates of <u>all</u> persons receiving services under Medicaid, limiting the asset protection component of the partnership to the insured's lifespan. After the participant dies, states must recover what Medicaid spent from the estate, including protected assets.
  - → Section 1917(b) paragraph 3: prevents a state from waiving the estate recovery requirement for partnership participants.
  - → Section 1917(b) paragraph four subparagraph B: requires a specific definition of "estate" for partnership participants. States implementing a

partnership may be forced to use a broader definition of estates for partnership participants as a distinct group.

The financial and administrative feasibility of implementing the options identified will also be examined during demonstration Year 2.
Based on the outcome of the workgroup's feasibility study, the state will consult with the Legislature on the development of statutory language to permit the incentives to be put in place. It is anticipated that this would occur in demonstration Year 3.

Section P: Grievances & Appeals

Participants in the demonstration may file grievances about any matter that is not classified as an "Action" (see below), such as grievances with respect to the quality of service provided or aspects of interpersonal relationships with providers or the staff of state agencies. Grievances may be filed in writing or verbally with the DAIL within 60 days of the occurrence of the pertinent issue. Grievances are generally resolved by DAIL within 45 days of their receipt, although some cases may take longer depending on the individual's situation and the need for further evaluation. DAIL may also expedite an appeal if the individual's circumstances warrant more immediate action.

Individuals are also given the opportunity to appeal decisions made by the DAIL staff relative to program or clinical eligibility or the services provided for in their plan of care through the procedures outlined below. These decisions are considered "Actions" and include the following:

- a clinical or financial eligibility determination
- the denial or limited authorization of a requested service
- the reduction, suspension or termination of a previously authorized service or range of services
- denial, in whole or in part, of payment for a service
- failure to provide approved services in a timely manner
- failure to provide an approved service in a clinically indicated manner

Clinical Eligibility & Services Appeals

Clinical eligibility denials made by DAIL staff will result if the individual applicant does not meet the clinical eligibility criteria for receiving long-term care services, or because they have a primary diagnosis that would be more appropriately served through other state programs (e.g., CRT program). In these cases, the individual would receive a written notice from DAIL that includes information on the basis of the denial and an explanation of the appeal process (see Attachment P).

Based upon utilization review activities, DAIL staff may reduce or deny services requested on a service plan. In these cases, DAIL staff will send a copy of the revised, authorized service plan to the individual. That notice will also explain the individual's appeal rights.

The individual may appeal either type of action with or without legal representation. Individuals who desire legal representation are informed that they may contact Vermont Legal Aid for such assistance.

In order to appeal, the individual or their representative may request, in writing, an administrative review within 15 days of receipt of an eligibility denial notice or notice of a denied or reduced service plan. If a service reduction appeal is filed by the recipient within ten days of the notice of the reduction of a previously authorized service, those services will continue pending the outcome of the appeal. If the recipient does not succeed in having the service reduction overturned either through the DAIL administrative review process or through a fair hearing, s/he may be held financially accountable for the cost of the services provided during the interim period.

Upon receipt of the request for an appeal, DAIL will perform an administrative review of the individual's circumstances, examine case records, request additional information as needed from their case manager, and/or conduct an in-person interview, if necessary. Once sufficient information is obtained and reviewed, a final administrative review decision will made and a second notice will be issued. If the denial or reduction in services is upheld, that notice will include information on additional appeal rights.

Further appeals of the administrative review decisions of DAIL may be made to the Human Services Board within 30 days of receipt of the decision. Individuals enrolled in the demonstration always have the right to appeal directly to the state's Human Services Board.

The Long-Term Care Ombudsman is available, through Vermont Legal Aid, to provide assistance to individuals in the filing and processing of their appeals.

Financial Eligibility Appeals

Individuals may also appeal a denial of long-term care Medicaid financial eligibility or patient share determinations. Appeals of financial eligibility determinations shall follow regulations promulgated by the Department for Children and Families. The current regulations contain the following provisions: Appeal rights and procedures are communicated in a letter issued by the Department for Children and Families/Economic Services Division at the time the individual is notified of their eligibility denial or patient share of cost. The individual must file his/her appeal within 90 days of the mailing date of the notice from DCF, either in writing or by calling their local DCF office. The individual may also appeal directly to the Human Services Board.

Should the individual first file an appeal with DCF/ESD, staff will collect all relevant information on the financial circumstances of the individual as presented in their application and may further interview the applicant to obtain additional information. Following a review of the case file, DCF/ESD will either uphold or overturn the eligibility denial. All financial eligibility appeals will be processed within 30 days of the receipt of the appeal.

If the denial is overturned and eligibility is confirmed, the individual will be so noticed and coverage will be effective as of the original date of the application.

If the denial is upheld, the individual will be notified of the denial and further apprised of their right to appeal that decision to the Human Services Board. Appeals to the Human Services Board must be made within 90 days of the DCF notice of an eligibility denial.

The same process is followed for patient share of cost determination appeals.

Monitoring of Appeals

The grievance and appeal process is closely monitored internally by staff attorneys and externally by Vermont Legal Aid. DAIL program managers receive periodic reports on the number and type of appeals and their resolution timeframes and status (upheld, overturned, partially overturned). The Quality Management and Improvement unit within DAIL is responsible for coordinating corrective action when aberrant patterns of grievances and appeals are identified, or when the number of overturned appeals exceeds a certain threshold.

Section Q: Evaluation Design

The Department will create an advisory group to assist DAIL in the development of the design of the evaluation component of this demonstration. Representatives of the following organizations will be invited to participate:

- ✓ AARP, Vermont Office
- ✓ Area Agencies on Aging
- ✓ Community of Vermont Elders
- ✓ Office of Vermont Health Access (Agency of Human Services)
- ✓ Vermont Assembly of Home Health Agencies
- ✓ Vermont Association of Adult Day Services
- ✓ Vermont Center for Independent Living
- ✓ Vermont Legislature
- ✓ Vermont Health Care Association

The advisory group will also provide input to DAIL on the development of an RFP, which will be used to select an organization(s) to conduct the evaluation. The organizations Vermont anticipates contacting include the following:

- ✓ National Academy for State Health Policy
- ✓ Miami University Scripps Gerontology Center
- ✓ University of Massachusetts Center for Health Policy and Research
- ✓ Muskie School of Public Service, Institute for Health Policy
- ✓ Center for the Aging, Dartmouth Medical School
- ✓ University of Vermont

The selected evaluation contractor will be responsible for the final design of the evaluation, in consultation with the Department of Disabilities, Aging and Independent Living.

Initial elements under consideration for the evaluation component include the following:

- Changes in access to Home- and Community-Based Services
- Changes in the range of long-term care options
- Changes in the quality of long-term care services
- Changes in system performance measures (e.g. time from applying for HCBS to receiving HCBS)
- Changes in the nursing facility census and acuity levels

- Determining if services provided to members of the Moderate Needs group prevent or delay the use of more intensive services by these individuals
- Consumer satisfaction levels

Vermont has core datasets which are available for use in the evaluation. These data are collected through a variety of methods including the assessment and re-assessment process, information collected in the course of program monitoring activities, claims for services, surveys, etc. Specifically DAIL anticipates that the following datasets will be used in conducting the evaluation:

- Individual assessment data, via the SAMS 2000 database
- Medicaid paid claims
- ORC MACRO participant survey (satisfaction) data
- MDS assessment data (assuming such use is approved through a data use agreement with CMS)
- Nursing facility occupancy rates
- Results from other written, telephone or focus group surveys

Vermont will also seek to answer the following questions with respect to the demonstration:

- Which functional, cognitive and medical measures are the best predictors of individuals at risk for institutional placement in the medium term (12-24 months)?
- Is it more cost effective for the overall long-term care program to furnish a comprehensive package of HCB services to individuals based on their specific needs than to operate a system with an institutional bias? Is the overall cost lower on a per participant basis?
- If a care plan including HCB services is implemented early enough, can the need for nursing facility care be significantly delayed or eliminated?
- Are participants more satisfied under the demonstration than was the case with the historical program?
- Do educational and outreach efforts expand the level of knowledge in the community with respect to long-term care resources?

Given the comprehensive and unique nature of this long-term care demonstration, the state does not expect to encounter any problems in isolating the effects of the program on the enrolled population. The state does not expect any other long-term care initiatives of this nature being implemented during the

five-year period. Basic shifts in population demographics (e.g., aging of the population) are identifiable and can be controlled for when conducting the various analyses attendant to the evaluation.

As the evaluation process unfolds, the state will use any interim findings to make improvements in its processes and procedures across all operational areas of the program. These findings will also be summarized in the state's annual report to CMS.